CMHC NAME:
EPSDT INITIAL INTENSIVE HOME-BASED SERVICES (IHBS) REFERRAL FORM

Service(s) Being Referred

___ ***Intensive Care Coordination*** ___ ***In-Home Intervention*** ___ ***Therapeutic Mentoring***

___ ***Certified Peer Specialist – Youth*** ___ ***Certified Peer Specialist - Parent***

Case Number:

Referring Agency: _____ Date of Referral: _____

Referring Person: _____ Phone: _____

Original referral source, if different from above: _____

Youth Information (IF THE FIELD IS LEFT BLANK, see EHR)

Name: _____ SSN: _____ Date of Birth: _____ Age: _____

Race/Ethnicity: _____ Gender: _____

Caregiver Name: _____ Relationship to Child: _____

Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Insurance Information: _____

Indicate if the youth is engaged with any or all of the following (IF FIELD IS LEFT BLANK, see EHR):

Special Education ☐ Yes ☐ No 504 Plan: ☐ Yes ☐ No

School: _____ Grade: _____

DHR: ☐Foster Care ☐ In Full Custody ☐ Open to Protected Services DHR worker/phone: _____ / _____

Juvenile Court: ☐ Yes ☐ No Pending Case/Probation: ☐ Yes ☐ No JPO: worker/phone: _____ / _____

DYS: ☐ Involved ☐ In custody DYS worker/phone: _____ / _____

Adult Justice System: ☐ Yes ☐ No Pending Case/Probation: ☐ Yes ☐ No PO: worker/phone: _____ / _____

IDD: ☐ Involved IDD worker/phone: _____ / _____

ASD: ☐ Involved ASD worker/phone: _____ / _____

SUD: ☐ Involved Treatment agency/phone: _____ / _____

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Current Mental Health Treatment: ☐ Agency: _____ Phone: _____

Treating Psychiatrist: _____

Current Diagnoses: _____

Current Medications: _____

Current Inpatient Psychiatric Hospitalization: ☐ Agency: _____ Phone: _____

Current Psychiatric Residential Placement (PRTF): ☐ Agency: _____ Phone: _____

Current ER/General Hospital Placement: ☐ Agency: _____ Phone: _____

Medical Care: ☐ Yes ☐ No Major Medical: _____

PCP: _____ Phone: _____

County Multi Needs Involvement: ☐ Yes ☐ No State Multi Needs Involvement: ☐ Yes ☐ No

Receiving other services (specify): _____

Mental Health History (IF FIELD IS LEFT BLANK, see EHR)

Previous Inpatient/Outpatient Mental Health Services/Placements:

_____

Previous Diagnoses: _____

Previous Treatment Provider(s): _____ Phone: _____

Previous Treating Psychiatrist: _____ Phone: _____

Previous medications (please list): _____

General Mental Health / Diagnosis Comments (IF FIELD IS LEFT BLANK, see EHR)

_____

Eligibility Screening *(please check all that apply)*

☐ The youth has a serious emotional disturbance (SED), as approved by SAMHSA, and/or a serious mental illness (SMI).

☐ The youth has intensive needs due to their serious emotional disturbance.

☐ The youth is involved in multiple child-serving systems.

☐ The youth has had one or more episodes of inpatient or residential treatment

☐ The youth's treatment requires cross-agency collaboration.

☐ The youth and their parent, guardian or foster parent reside in a county served by the Alabama Department of Mental Health approved CMHC that covers this catchment area.

☐ The caregiver/family has requested/volunteers for this service and agrees to actively participate.

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FOR INTERNAL USE ONLY – ONLY COMPLETE FOR THOSE SERVICES INDICATED ON INITIAL REFERRAL

Certified Parent Peer Support (CPS-P)

Eligible for service? ☐Yes ☐ No

If no, why?

Date CPS-P Offered to Parent/Caregiver: _____

Accepted service: ☐Yes ☐No _____

CPS-P Assigned _____ Date Assigned: _____

Certified Youth Peer Support (CPS-Y)

Eligible for service? ☐Yes ☐No

If no, why? _____

Date CPS-Y Offered to Youth/Young Adult: _____

Accepted service: ☐Yes ☐No _____

CPS-Y Assigned _____ Date Assigned: _____

Therapeutic Mentoring (TM)

Eligible for service? ☐Yes ☐No

If no, why? _____

Date TM Offered to Family: _____

Accepted service: ☐Yes ☐No _____

TM Assigned _____ Date Assigned: _____

Intensive In-Home Intervention (IHI)

Eligible for service? ☐Yes ☐No

If no, why? _____

Date IHI Offered to Family: _____

Accepted service: ☐Yes ☐No _____

IHI Assigned _____ Date Assigned: _____

Intensive Care Coordination (ICC): Indicate either LICC or HICC: _____

Eligible for service? ☐Yes ☐No

If no, why? _____

Date ICC Offered to Family: _____

Accepted service: ☐Yes ☐No _____

ICC Assigned: _____ Date Assigned: _____